STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING _____ B. WING _____	03/10/2011

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COMMUNITY NORTHVIEW CARE CENTER	1235 WEST CROSS STREET ANDERSON, IN46011

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F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure survey completed on 1/25/11. Survey dates: March 9 and 10, 2011 Facility number: 000562 Provider number: 155718 AIM number: 100267150 Survey Team: Toni Maley, BSW, TC Donna M. Smith, RN Tammy Alley, RN Census Bed Type: SNF: 4 SNF/NF: 73 Residential: 26 Total: 103 Census Payor Type: Medicare: 18 Medicaid: 43 Other: 42 Total: 103 Sample: 11 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-15-11 Cathy Emswiller RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0315 SS=E	5.) Resident #18's record was review on 3/9/11 at 2:45 p.m. Resident #18's current diagnoses included, but were not limited to, Alzheimer's disease and Parkinson's disease. Resident #18 had a current 2/20/11, physician's order for an anchored catheter. Resident #18 had a history of urinary tract infections and was most recently evaluations and treatment for a urinary	F0315	The plan of correction for F 315 will be to ensure that all residents who have an indwelling catheter have the proper catheter care as to prevent infections. The facility will ensure that residents #61,#45,#2,and #18 will be monitored closely during tranfers to prevent the possibiity of infections. Before the facility recieved the 2567 every nursing employee was educated on how to transfer a resident with a catheter. The employee was then responsible for completing a return demonstration in front of their supervisor proving their competence with this skill. This was completed by April 25th 2011.Since receiveng the 2567 the facility has called in a Certified Clinical Nurse Specialist to train all employees on . The Nurse specialist will meet with the facility on the 28th of March and is planning to complete 3 inservices at the facility on April 4,5,and 6. The documentation proving evidence of this directed in-service training will be sent to the ISDH as verification of completion by April the 11th, 2011.The facility will continue(after all nursing employees are trained) to mandate that employees pass the return demonstration competency in order to remain an employee of Community Northview Care center. The Facility will Provide competencies regarding catheter	04/09/2011

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	tract infection as follows: a.) A 2/17/11 urine culture and sensitivity with a result of a urinary tract infection with greater than 100,000 gram negative bacilli. b.) a 2/20/11- Bactrim DS (an antibiotic)-1 tablet two times daily for 10 days for the treatment of a urinary tract infection. On 3/09/11 from 10:20 a.m. to 10:45 a.m., Resident #18 personal		placement and transfers every 6 months. All New employees will be trained on this deficiency before they are able to work at Community Northview Care Center. The Director of Nursing will be responsible for keeping all documentation regarding this deficiency and will ensure that all nursing staff are trained properly and timely.The DON will be responsible for providing and reporting on the progress of this deficiency at our QA meetings.The facilities RN supervisors will continue to spot check 5 employees a week in order to ensure this deficient practice does not recurr. All documentatin will be given to the DON regarding these 10 spot checks weekly.This will be an ongoing process and will be completed by April 9, 2011	

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	care and transfer were observed. After completing the shower and dressing the resident, CNA #7 was observed to hook the resident's Foley catheter (F/C) bag onto her arm positioning it above the resident's urinary bladder. Yellow urine with white sediment was observed in the F/C tubing and bag. The resident was then stood up from the shower chair as CNA #8 dried the resident's buttocks before her brief and pants were pulled up.			

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	After the resident was transferred to her wheelchair, CNA #7 lowered the resident's F/C bag below her bladder level and hooked it under the resident's wheelchair. At this same time during an interview, CNA #7 indicated she knew the F/C bag/tubing was not to touch the floor or one's uniform. She indicated the F/C bag would touch one's uniform when hung from one's pocket. She indicated she was not aware the F/C tubing/bag should not be held above			

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	the resident's bladder. This Federal tag was cited on 1/25/11. The facility failed to implement a systemic plan of correct to prevent recurrence. 3.1-4(a)(2)			

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F0315 SS=E	Based on record review, observation, and interview, the facility failed to ensure anchored catheter drainage bags and tubing were positioned in a manner to prevent the possibility of infection for 4 of 4 residents reviewed with anchored catheters in a sample of 11. (Resident # 61, # 45, # 2, and # 18) Findings include: 1. A May 2002 policy titled "Anchored Catheter Care" was provided by the Director of Nursing on 3/10/11 at 10:20 a.m., and deemed as current. The policy indicated: "...1. Urinary drainage bag will be kept below the bladder to assure adequate urine flow form the bladder. Secure to avoid touching the floor...." 2. The record for Resident # 61 was reviewed on 3/9/11 at 11:25 a.m. Current diagnoses included, but were not limited to urinary retention. Current physician orders for March 2011 indicated an order for an anchored catheter. A Physician order dated 2/8/11 indicated an order for a urinalysis with a culture and sensitivity.	F0315	The plan of correction for F 315 will be to ensure that all residents who have an indwelling catheter have the proper catheter care as to prevent infections. The facility will ensure that residents #61,#45,#2,and #18 will be monitored closely during tranfers to prevent the possibiity of infections. Before the facility recieved the 2567 every nursing employee was educated on how to transfer a resident with a catheter. The employee was then responsible for completing a return demonstration in front of their supervisor proving their competence with this skill. This was completed by April 25th 2011.Since receiveng the 2567 the facility has called in a Certified Clinical Nurse Specialist to train all employees on . The Nurse specialist will meet with the facility on the 28th of March and is planning to complete 3 inservices at the facility on April 4,5,and 6. The documentation proving evidence of this directed in-service training will be sent to the ISDH as verification of completion by April the 11th, 2011.The facility will continue(after all nursing employees are trained) to mandate that employees pass the return demonstration competency in order to remain an employee of Community Northview Care center. The Facility will Provide competencies regarding catheter	04/09/2011

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	A nursing note dated 2/9/11 at 12:16 p.m., indicated 100 milliliters of cloudy urine was obtained for the above test. A 2/11/11 final lab report indicated the resident had Escherichia Coli and Gram Negative Bacilli in his urine. A 2/12/11 physician order indicated an order to monitor temp for 72 hours, give 4 ounces of cranberry juice with each meal and 4 ounces of water each shift. During an observation on 3/9/11 at 11:15 a.m., Resident # 61 was transferred to the toilet by CNA # 1. She began the transfer by unhooking the anchored catheter bag from under the wheelchair and placed the bag and tubing on the floor under the wheelchair. There was urine in the bag and tubing. She then hooked the anchored bag onto the arm of the wheelchair, stood the resident up and transferred him to the toilet. During the transfer the catheter tubing began to pull, CNA # 1 then tossed the anchored catheter bag and tubing onto the floor beside the toilet. After several minutes, the CNA then picked up the anchored catheter bag and hung it on the footrest of the wheelchair, with the drainage bag touching the floor. She transferred the		placement and transfers every 6 months. All New employees will be trained on this deficiency before they are able to work at Community Northview Care Center. The Director of Nursing will be responsible for keeping all documentation regarding this deficiency and will ensure that all nursing staff are trained properly and timely.The DON will be responsible for providing and reporting on the progress of this deficiency at our QA meetings.The facilities RN supervisors will continue to spot check 5 employees a week in order to ensure this deficient practice does not recurr. All documentatin will be given to the DON regarding these 10 spot checks weekly.This will be an ongoing process and will be completed by April 9, 2011	

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resident to the wheelchair and then transferred him to his bed. When completed she hooked the anchored catheter drainage bag to the bed frame with the drainage bag touching the floor.

During an interview on 3/9/11 at 11:40 a.m., CNA # 1 indicated she was aware she had place the anchored catheter drainage bag and tubing on the floor 2 times. She indicated the drainage bag and tubing were not supposed to be placed or let touch the floor.

3. The record for Resident # 45 was reviewed on 3/9/11 at 1:45 p.m.

Current physician orders for March 2011 indicated an order for an anchored catheter.

A 12/9/10 urinalysis and culture and sensitivity indicated the resident had Gram Negative Bacilli in her urine.

A 12/17/10 at 7:45 p.m., nursing note indicated the resident was started on Keflex 500 milligrams (antibiotic) three times a day for a urinary tract infection.

During an observation on 3/9/11 at 11:10 a.m., Resident # 45 was in her room in her wheelchair with her anchored catheter

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	tubing laying on the floor under the wheelchair. At that time, during interview, CNA # 3 indicated the catheter tubing was missing the clip so she had been unable to clip the tubing up. 4. The record for Resident # 2 was reviewed on 3/9/11 at 12 p.m. Current physician orders for March 2011 indicated an order for an anchored catheter. During an observation on 3/9/11 at 10 a.m., Resident # 2 was transferred by hoyer lift from her wheelchair to her bed. LPN # 4 removed the anchored catheter bag from the wheelchair and placed it on the floor under the resident's chair. There was urine in the drainage bag and tubing. When the resident was lifted up in the hoyer, the drainage bag was place on the hoyer lift above the level of the bladder. During an interview on 3/9/11 at 10:05 a.m., LPN # 4 indicated she was aware she had place the drainage bag and tubing on the floor. She indicated she was unsure where to put the drainage bag during a hoyer transfer.			

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F0315 SS=E		F0315	The plan of correction for F 315 will be to ensure that all residents who have an indwelling catheter have the proper catheter care as to prevent infections. The facility will ensure that residents #61,#45,#2,and #18 will be monitored closely during tranfers to prevent the possibiity of infections. Before the facility recieved the 2567 every nursing employee was educated on how to transfer a resident with a catheter. The employee was then responsible for completing a return demonstration in front of their supervisor proving their competence with this skill. This was completed by April 25th 2011.Since receiveng the 2567 the facility has called in a Certified Clinical Nurse Specialist to train all employees on . The Nurse specialist will meet with the facility on the 28th of March and is planning to complete 3 inservices at the facility on April 4,5,and 6. The documentation proving evidence of this directed in-service training will be sent to the ISDH as verification of completion by April the 11th, 2011.The facility will continue(after all nursing employees are trained) to mandate that employees pass the return demonstration competency in order to remain an employee of Community Northview Care center. The Facility will Provide competencies regarding catheter	04/09/2011

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			placement and transfers every 6 months. All New employees will be trained on this deficiency before they are able to work at Community Northview Care Center. The Director of Nursing will be responsible for keeping all documentation regarding this deficiency and will ensure that all nursing staff are trained properly and timely.The DON will be responsible for providing and reporting on the progress of this deficiency at our QA meetings.The facilities RN supervisors will continue to spot check 5 employees a week in order to ensure this deficient practice does not recurr. All documentatin will be given to the DON regarding these 10 spot checks weekly.This will be an ongoing process and will be completed by April 9, 2011	

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F0328 SS=D	Resident #61's record was reviewed on 3/9/11 at 11:25 a.m. Resident #61's current diagnoses included, but were not limited to, hypoxia, chronic obstructive pulmonary disease and Alzheimer's disease. Resident #61 had a 1/14/11, current, physician's order for oxygen to be administered at a flow rate of 3 liters a minute per nasal canula.	F0328	the plan of correction for F328 will be to ensure residents #50 and #61 have their oxygen set at the flow rate as ordered by a physician. Resident #50 and #61 will have their flow rates checked and documented daily until April 9th 2011. Every other resident recieving oxygen will also have their flow rates checked and verified daily until April 9th 2011. The facility will then complete weekly spot checks ongoing to ensure that this does not recurr. The spot checks will be documented and obtained by the DON for review and completion.The directed inservice training regarding this deficiency will take place on April 4th, 5th and 6th. The training is be;ing completed by a Certified Clinical Nurse Specialist hired by the facility to train our nursing staff. The imformation rewgarding this training will be sent to The ISDH by april the 11th 2011.As part of our new hire orientation all nursing staff will recieve our policy and traing on o2 administration.The oxygen flow rate will be documented on the CNA assignment sheets daily to help remind them to check and notify a Nurse if oxygen is not correct.The DON will be responsible for providing all documentaion at the QA meeting for review and changes.The Plan of correction date for this deficiency is April 9th 2011.	04/09/2011

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	Resident #61 had a current 1/25/11, care plan problem regarding the residents need for oxygen therapy due to chronic obstructive pulmonary disease. An approach to this problem was to administer oxygen at a 3 liter flow rate. On 3/9/11 at 11:05 a.m., Resident #61 was observed seated in his wheelchair with a portable oxygen tank in place. The flow rate on the portable oxygen tank was set at 2 liters.			

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	On 3/9/11 at 11:20 a.m., Resident #61 was observed receiving care in his room with the portable oxygen tank in place. The oxygen flow rate continued to be set at 2 liters. During an interview at this time LPN #4 indicated the residents oxygen was set at the incorrect flow rate and should be set at 3 liters as ordered. This Federal tag was cited on 1/25/11. The facility failed to implement a systemic			

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	plan of correct to prevent recurrence. 3.1-47(a)(6)			

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	155718	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NORTHVIEW CARE CENTER	1235 WEST CROSS STREET ANDERSON, IN46011

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F0328 SS=D	Based on record review, observation and interview, the facility failed to ensure oxygen was set at the physician ordered flow rate for 2 of 4 residents reviewed for oxygen administration in a sample of 11. (Resident # 50 and # 61) Findings include: 1. The record for Resident # 50 was reviewed on 3/9/11 at 3 p.m. Current diagnoses included, but were not limited to, pneumonia. Current physician orders for March 2011 indicated an order for oxygen to be administered at 2 liters. During the initial tour on 3/9/11 at 9:15 a.m., RN # 5 checked the flow rate of resident # 50's oxygen on her portable oxygen tank as she was sitting in the lounge. It was on 2 liters. The RN then indicated the flow rate should be 3 liters and changed the flow rate to 3 liters. During an observation on 3/9/11 at 3 :30 p.m., Resident # 50 was in her room. Her concentrator was set at 3 liters. At that time LPN # 6 indicated the flow rate should have been 2 liters and changed the flow rate to 2 liters.	F0328	the plan of correction for F328 will be to ensure residents #50 and #61 have their oxygen set at the flow rate as ordered by a physician. Resident #50 and #61 will have their flow rates checked and documented daily until April 9th 2011. Every other resident recieving oxygen will also have their flow rates checked and verified daily until April 9th 2011. The facility will then complete weekly spot checks ongoing to ensure that this does not recurr. The spot checks will be documented and obtained by the DON for review and completion.The directed inservice training regarding this deficiency will take place on April 4th, 5th and 6th. The training is be;ing completed by a Certified Clinical Nurse Specialist hired by the facility to train our nursing staff. The imformation rewgarding this training will be sent to The ISDH by april the 11th 2011.As part of our new hire orientation all nursing staff will recieve our policy and traing on o2 administration.The oxygen flow rate will be documented on the CNA assignment sheets daily to help remind them to check and notify a Nurse if oxygen is not correct.The DON will be responsible for providing all documentaion at the QA meeting for review and changes.The Plan of correction date for this deficiency is April 9th 2011.	04/09/2011

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F0363 SS=D	Based on observation, interview and record review, the facility failed to ensure a resident who had a physician's order for a low potassium diet had a menu developed and served for 1 of 1 resident with a low potassium diet order in a sample of 11 (Resident #30). Findings include: 1.) A review of a current, undated, facility menu for 3/9/11 and 3/10/11, which was provided by the	F0363	The Plan of correction for F 363 will be to ensure that resident #30 recieves the proper diet. The Dietician has been in and reviewed and made the proper changes (per Physicians Order) to ensure that this resident recieves the proper diet.In order to ensure that all other resident's recieve the proper diet the facility reviewed every diet in the facility and will continue to review those on a weekly basis during our Nutrition at risk weekly meeting. The facility dietician will also review every diet in the building on weekly visits to ensure the facility offers and maintains that diet.All staff willbe trained on the diets the faacility offersand a list will be maintained in the Nur;sing and Dietary Department of the facilities.The admission nurse will also have a list of the diets offered in order to ensure that the diet is ordered will be given.Since all staff might pass trays in the dining room the Directed in-service training will be given to all staff in the building.The food service supervisor will review on at least 2 meals weekly to ensure the proper diets are being served. This information will be documented and given to the administrator for review on a weekly basis. The results of all training and checks will be provided at our QA for review and changes.The facility will train all new employees on how to read	04/09/2011

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	administrator on 3/9/11 at 11:10 a.m., lacked any menu for a low potassium diet. 2.) During a 3/9/11, 11:30 a.m., to 12:00 p.m., lunch meal observation, Cook #2 was observed serving a meal to Resident #30. Resident #30's meal card indicated the resident had a physician's order for a no concentrated sweets, low potassium diet. During an interview at that time, Cook #2 indicated the facility did not have a		and understand diet orders to help ensure that all staff is trained.The plan of correction for this ongoing process will be April 9th 2011.	

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	current menu for a low potassium diet. She indicated she had a copy of an old menu which she used to decide what to serve the resident. Cook #2 served Resident #30 the following: a.) 3 ounces of roast beef without gravy b.) 4 ounces of cooked carrots without butter. c.) 4 ounces of tomato juice, which Cook #2 indicated she was serving as a substitute for potatoes which the			

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	resident could not have. d.) a slice of wheat bread e.) no sugar added baked apples topped with cinnamon. 3.) During a 3/9/11, 3:05 p.m., interview, the Food Services Supervisor indicated the facility did not have a current menu for a low potassium diet. She indicated the facility had a form titled "Foods High in Potassium"			

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	which was in the kitchen at the time of the 3/9/11 lunch service. She indicated the form had been moved to the far side of the room in error. She indicated although the facility did not have a menu for low potassium diets the cook should have used the form for guidance when serving Resident #30's diet. 4.) Review of an undated, current facility form titled "Foods High in Potassium", which was provided by the			

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	Food Services Supervisor on 3/9/11 at 3:05 p.m., indicated the following items were "Potassium Rich Foods" a.) apples b.) meats c.) carrots d.) wheat bread e.) tomatoes 5.) Resident #30's clinical record was reviewed on 3/9/11 at			

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	2:40 p.m. Resident #30's current diagnoses included, but were not limited to, diabetes and expressive aphasia. Resident #30 had a current, 4/7/10, physician's order for a no concentrated sweets, low potassium diet. Resident #30 had a current, 2/16/11, care plan problem/need related to high potassium levels. An approach to this problem was to			

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	serve a decreased potassium diet. Resident #30 had a, 2/14/11, potassium laboratory blood test, which indicated the resident had a high potassium of 5.2 with a normal range being 3.6 to 5.0. This Federal tag was cited on 1/25/11. The facility failed to implement a systemic plan of correct to prevent recurrence.			

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R0000	3.1-20(i)(1) 3.1-20(i)(4)	R0000		

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